TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY

REPORT A

December, 1989

Manitoba

92-05392/

Health Advisory Network

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March 23, 1990

Dear Colleague:

The Task Force on Health Services for the Elderly has completed an Interim Report on health promotion for the elderly. This Interim Report was formally received by the Health Advisory Network Steering Committee.

Consistent with the Minister of Health's desire to ensure adequate consultation, the Steering Committee invites input from those affected by the recommendations of the Task Force before it formalizes its own recommendations. A copy of the Interim Report of the Task Force is enclosed for your review and response. Copies have been distributed to more than twenty organizations and groups for comment.

The sequence of the consultation process is outlined below:

1) The Interim Report of the Task Force was received by the Steering Committee.

2) The Steering Committee distributes the Interim Report to interested parties in the community for comment.

3) The community responses are to be forwarded to the Task Force for review in April, 1990.

4) The Task Force will submit its final Report to the Steering Committee, taking into account the reactions to the Interim Report.

5) The Steering Committee will review the final Report of the Task Force to formulate options and recommendations for consideration by the Minister of Health.

Your written response to the Interim Report of the Task Force should be received on or before April 23, 1990.

Please send twenty copies of your comments to:

Health Advisory Network
308 - 294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Yours truly,

Brian Rudmundson for

Arnold Naimark, M.D.
Chair
Health Advisory Network Steering
Committee

Enc.

HAN.EXT-REP

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TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY

A) Interim Report on Health Promotion

Mandate

The mandate of the Task Force focuses on the following with respect to the elderly: coordination/integration among health care programs; means to improve service gaps within the health care system; steps to improve communication within the health care system; and means to improve admission and discharge policies for treatment decisions within hospitals, personal care homes, and home care services. Dr. Naimark's meeting with the Task Force emphasized the need to focus particularly on coordination/integration and gaps in the health care system.

Deliberations are to result in action oriented recommendations which are acceptable to relevant constituencies. Recommendations are to take health care costs into consideration.

Underlying Assumptions

The World Health Organization's definition of health is adapted for the purposes of this Task Force. This definition is broad, including economic, social, psychological, emotional, spiritual, environmental, and medical aspects as relevant to one's health. Health is seen as a resource to living and not an end in itself. Health is more than the absence of disease. The work of this Task Force, in other words, is not restricted to medical and biological aspects of health.

Further, it is assumed that elders, like others, are entitled to a high quality of life which includes maintaining their autonomy and well-being for as

long as possible. This encompasses their right to make their own decisions and to take responsibility for their own health.

Finally, no one lives in a vacuum, isolated from others. In examining the health care needs of elders it is relevant and necessary to also examine their family, friendships, and instrumental ties within the community. Examining the needs of the caregiver has important consequences for the health and health care of the elder.

A Means to Proceed

It was agreed that a classification scheme was necessary to proceed with some order imposed on the discussions. The following service categories were chosen for discussion in the order in which they appear below:

1. Health Promotion:

Health promotion is the process of enabling people to increase control over their health and to improve their health. This includes: services directed towards an increased dialogue on and awareness of the values, attitudes and lifestyles which are consequential for one's health. Knowledge is assumed necessary for self-empowerment and the exercise of individual choice. Examples of services which are directed towards health promotion include Creative Retirement Manitoba, various senior centres, Age & Opportunity Centre Inc., the provincial Health Promotion department, the federal New Horizons programs, nutrition programs, etc.

2. Illness Prevention:

Illness prevention refers here to health care services which are disease specific (to distinguish them from health promotion activities). They are directed to the prevention of disease and include programs such as vaccines, foot care, programs offered through the Alcohol Foundation and the Lung Association.

3. Treatment Services

a) Acute Care - refers to curative health care services provided in immediate response to diagnosed illness or injury. For example, acute care hospitals and physician services.

b) Chronic Care - refers to long-term health care services provided in response to diagnosed illness or injury. They include services offered to assist with: (i) disability postponement - which include all rehabilitation services, such as occupational therapy, physical therapy, speech therapy, pastoral services, and equipment; (ii) maintenance care - refers to health services to maintain health where the curative results of acute care services have been maximized and include, for example, personal care homes, extended care treatment beds, and supportive housing.

c) Terminal care - refers to care services for dying patients and their families. They include services such as palliative care, hospices, personal care homes, physicians visiting the home, extended care beds, and pastoral care.

Health Promotion

There is strong agreement from both Task Force members and those appearing before the Task Force, that the area of health promotion is not clearly targeted within the health care system. Relatively little attention is directed at health promotion compared with treatment. Indeed it is difficult to know what efforts are taking place in health promotion or to quantify such efforts because they are fragmented and tend not to be monitored. Nevertheless, Manitoba's Health Advisory Network estimates that between 5% - 10% of the health care budget is spent on the promotion of health and prevention of disease (see Terms of Reference for the Health Promotion Task Force). The Canadian Nurses Association estimates between 3% - 5% of any province's health care expenditures are for health promotion or community health services (in their testimony before the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women of the House of Commons). Efforts in this area are frequently shunted from one jurisdiction to the next as a result of disputes over whether health or education should fund such endeavours.

> It is recommended that the Health Promotion Program of the Department of Health begin immediately documenting health promotion programs (both governmental and non-governmental) for the elderly which currently exist and, where appropriate, establish monitoring mechanisms.

This is seen as a first step in the health promotion area and will not be costly. It is possible that current staff could absorb these tasks.

Health promotion can be addressed in terms of four audiences: elders; informal caregivers; those working with the elderly; and the general public.

Elders

There is need for better information for elders, both in terms of the services that are available and how to access them as well as information which will help them decide which services will best meet their needs. Recent effort to establish such an information line through the Seniors Secretariat did not consult with the voluntary sector in Winnipeg which has been performing this function on shoestring budgets for many years. This voluntary sector did not participate in finding the most appropriate solution for this gap.

The solution need not involve more dollars as dollars are already allocated through the Seniors Secretariat for this function (except for expansion to 24-hour coverage). The question is whether a new and unknown organization (such as the Seniors Secretariat) is the most appropriate and efficient locale to provide this service. One option is to provide the funds to Age & Opportunity Centre Inc. to expand their longstanding operation in this area. If not, there must be a mechanism in place to avoid duplication of services and to ensure that those who call the new line are not simply referred to other agencies such as the Age & Opportunity Centre Inc. Key to finding the appropriate solution is dialogue and coordination with the voluntary sector which has been meeting some of the need in this area for a long time.

> It is recommended that the Seniors Secretariat, together with Age & Opportunity Centre Inc., the Manitoba Society of Seniors, and other relevant parties, begin discussions immediately on how to best offer this needed service to seniors.

In addition, there is a need for heightened awareness and knowledge of the aging process generally and of condition-specific information. More general education which permits informed choices within everyday living can lead to

self-care, mutual care and empowerment for this age group which has met with ageist attitudes within society for numerous decades. It is recognized that there must be a desire for the information and a willingness to use it. Any number of topics are included, such as: diet, education for retirement, knowledge of good foot care, knowledge about medications and information regarding patients' rights to question and dialogue with health care workers. Little of this work is currently done by the provincial Department of Health. The community development work within the Support Services to Seniors program is an exception. This program is underutilized in Winnipeg and non-existent in the northern regions of Norman and Thompson.

Given the lack of monitoring and evaluation within the area of health promotion, the Task Force feels that the non-existent Support Services to Seniors program in the northern regions presents an opportunity for a natural experiment. Any areas within Norman or Thompson, such as Flin Flon or The Pas, could be compared with one such as Hamiota or Portage la Prairie, which have well-developed Support Services to Seniors programs. Such a comparison could rigorously test the success of this program.

> It is recommended that rigorous evaluation research be conducted comparing an area not receiving Support Services to Seniors with an area receiving well-developed services from this program.

If this evaluation is to take place it is imperative that sufficient monies (probably in excess of $150,000) be allocated for an appropriate evaluation. Further:

> It is recommended that the government's plans for progressive expansion of the Support Services to Seniors program be continued.

The voluntary sector provides worthwhile and significant health promotion services to seniors. There are agencies within the City of Winnipeg and the Province of Manitoba which have longstanding histories and international reputations for their valuable health promotion work with elders. Notable are Creative Retirement Manitoba, the Manitoba Society of Seniors, and the Age & Opportunity Centre Inc. While these agencies are currently receiving annual provincial funding for a portion of their operations, they need to be assured stable funding into the future for their health promotion activities.

Other non-governmental volunteer agencies within the province have not previously targeted the elderly but are now starting to shift some of their attention towards the aging of the population. No doubt the changing demographic trend is a reason for this. Examples here include Klinic as well as other community health centres. Frequently, it is these agencies who work with the isolated and hard to reach as well as the "socially incompetent" which government programs sometimes find "inefficient" to keep within their system. The universities, especially the University of Winnipeg, target some programs to seniors.

> It is recommended that a committee representing the provincial Departments of Health and Education, together with representation from all non-governmental agencies, begin immediately to discuss coordination of their efforts and overall strategies in the health promotion area. This should include a definition of the roles and functions of the various organizations.

Health promotion programs will require an injection of additional funds: funds for both new programming and for evaluations of both new and old programs. There is no system which monitors the effectiveness or efficiency of health promotion programs. One would expect that a variety of programming is

necessary. For example, programs for the well-elderly may find that the senior centres are an appropriate location, whereas for frail elders the space within long-term care facilities might be an appropriate location. It is to be noted that long-term care facilities are frequently forgotten when discussing health promotion.

> It is recommended that long-term health care facilities be encouraged to participate in health promotion activities (for example, illness prevention programs around alcohol use such as peer consultation programs).

This may or may not cost additional dollars, depending on the activity involved. For example, meetings for support groups run by the Manitoba Chapter of the Alzheimer Society at a particular facility would not involve additional costs.

Informal Caregivers

It is now well-documented (see Report on Formal Programs for Informal Caregivers by Chappell, prepared for the Social Policy Directorate, Policy Communications and Information Branch, Health and Welfare Canada) that it is the informal network, that is, family and friends, who provide the majority of care to elderly members of society. Family and friends are the "first resort" of assistance. This is true not only for Canada but all industrialized societies The many studies now appearing on stress and burden among caregivers, notabl those caring for the mentally impaired, have led to increased recognition of tl burden experienced by these individuals. If the individual is married, t spouse is almost always an informal caregiver. Second are children, notab daughters. With increased longevity, many of the children providing care

elders are themselves elderly. The vast majority of care is provided by women, both wives (because they tend to marry men older than themselves and men have a shorter life expectancy) and daughters.

Estimates suggest family and friends are providing about 80% of the care which elderly members of society receive (Chappell et al., 1986; Biaggi, 1980). It is estimated that only about 20% comes from the formal care system. It is easy to see that the informal network is critical to maintaining demand on the formal health care system at a level at which it can respond. Promoting and maintaining the health of caregivers, therefore, is critical.

Canada, like other industrialized nations, has no comprehensive policy or programming for caregivers. Canada, like all industrialized nations, however, is currently recognizing the need to support caregivers and programs are emerging in various jurisdictions. Since the types of services which caregivers themselves request (relief or respite, and support services) fall within home care services, it is within this program that they can be appropriately accommodated.

> It is recommended that the policies and programs of the Office of Continuing Care formally recognize the needs of informal caregivers.

It is recognized that Manitoba currently offers various forms of relief or respite care services through the Office of Continuing Care and that various volunteer agencies (such as the Manitoba Chapter of the Alzheimer Society and Rupertsland Respite Care) provide support for some caregivers. However, the programming may not be sufficient. For example, emergency respite is not easily available to Manitoba caregivers, especially in Winnipeg. Programming in this

area requires a thorough review to ensure that sufficient appropriate services are provided.

> It is recommended that specific programs for caregivers be reviewed and considered to ensure sufficient appropriate services are available. In particular, emergency respite care should be examined to ensure its availability. Similarly, support groups require stable funding as long as they are meeting a need.

Currently there are few programs which offer monetary relief for the caregiving function. Nova Scotia is the only province which has a program of monetary payment to elders for reimbursement to an informal caregiver. At the federal level, Veterans Affairs pays informal caregivers as sitter attendants. Neither of these programs are widespread. This is not unusual. Sweden and Norway stand as exemplars of modern societies who pay informal caregivers on a widespread basis. They both have programs in place to pay informal caregivers a standard wage comparable to formal homemakers for performing that function. Sweden is phasing this program out, whereas Norway is continuing its program which has historically been less professionalized than Sweden. In Norway, 29% of the homemaker workforce consists of paid informal caregivers.

There does not appear to be overwhelming support for this type of option in Canada or in Manitoba (see report noted above by Chappell for the federal government). There is, however, interest in providing a Canada Pension Plan option for those individuals who have been working full-time but then quit paid labour in order to provide the caregiver function. This would be an opting out clause so that those who quit paid labour in order to provide caregiving are not penalized in their pension schemes. Another option which seems to receive support in Manitoba is for some sort of tax concession for those who are providing caregiving.

It is recommended that the Manitoba government lobby the federal government in order to provide for both opting out provisions within CPP for those who quit paid labour in order to provide caregiving and work towards other tax concessions for such individuals.

Those Working With the Elderly

This Task Force supports the concern expressed by the Subcommittee on Health Services to the Elderly, Health Services Review, 1985, that instruction on both normal and abnormal aging as well as on the health care delivery system should be provided to students working with elders. However, the Task Force broadens the concern beyond professional workers to include all health care workers. This includes not only physicians, nurses and social workers, but also nursing assistants, activity directors, and homemakers, among others.

It is recommended that all educational programs which are targeted to health care workers include comprehensive study of the elderly and the process of aging. This includes the importance of attitudes and values towards the elderly.

This recommendation will involve primarily discussions with those responsible for curriculum development, rather than necessarily injection of funds. It will, however, take manpower to enlighten and persuade some groups that this is necessary and important.

General Public

It is not new to state that modern day society holds ageist attitudes. To be old carries with it images of dependency and no useful contributory role in society. In order for elders to experience self-empowerment, to be able to implement self-care and mutual assistance, to maintain their autonomy and

dignity, and to pioneer a new role for themselves and those of us who follow. society itself must change its negativism toward old age. It is therefore insufficient to target only those groups who work directly with elders. The general public requires more knowledge about the resources and potential of old age.

Through Creative Retirement Manitoba, elders enter some schools to provide positive images of aging to their students. The University of Manitoba is currently developing programs of study specializing in aging at both the graduate and undergraduate levels. These efforts are urgently needed but slow in developing because the study of aging is multidisciplinary and our educational systems are tied to disciplinary and other boundaries.

> It is therefore recommended that representatives from the Departments of Education and Health meet together with representatives from the universities and the school system to decide on the best immediate course of action to ensure that adequate, appropriate and current material on aging is incorporated within curricula.

The Task Force emphatically endorses this recommendation and urges it be given priority. This recommendation will require additional funding to ensure the developmental work comes to fruition. However, after the initial period (2-4 years) it would be expected that additional costs would be minimal as the curriculum changes become absorbed within the larger institutions.

Because health promotion has been so neglected, both within Manitoba and nationally, it is believed that those involved in the area and those providing funds to develop this area must do so within an experimental mode. In other words, results are not always immediate but that does not mean the long-term payoff is not highly beneficial.

There are, in addition, other areas relevant to health promotion services. For example, the issue of whether the existing health care delivery system permits the development of alternative delivery models such as those involving more health promotion activities has not been discussed here. Such issues will be considered later by the Task Force.

APPENDIX

Presentations To Task Force

Arnold Naimark	- Chair, Health Advisory Network
Farrell Fleming	- Executive Director, Creative Retirement Manitoba
Eric Lubosch	- Program Head, Services to Seniors, Manitoba Health
Betty Havens	- Provincial Gerontologist, Manitoba Health
Patti Sullivan	- Executive Director; Colin Muir - Community Development Worker - Klinic
Lynne Fineman	- Regional Continuing Care Coordinator, Winnipeg West Central, Manitoba Health
Hal Studholme	- Executive Director; Dorothy Hardy, Personal Services Manager, Age and Opportunity Centre
Richard Voss	- Regional Director, Winnipeg West Central, Manitoba Health
Dr. Allan Ranson, Pat Cochrane	- Hamiota District Health Centre
Tony Quaglia	- Executive Director, St. Boniface Hospital/Sister Clermont
Dr. Margaret Fast	- Director, Communicable Disease Control, Manitoba Health

Background Documents Distributed

Proceedings of the Fourth Manitoba Conference on Aging, May 1985, Winnipeg, Manitoba

The Provincial Fact Book on Aging - Manitoba. Prepared for the Fourth Manitoba Conference on Aging, May 1985, Winnipeg, Manitoba.

Manitoba Seniors Citizens' Handbook, Manitoba Council on Aging, Manitoba Health Winnipeg, Manitoba, 1988.

Chemical Dependence in the elderly: Identification Phase, William R. Jacyk et al, St. Boniface General Hospital, Winnipeg, Manitoba.

Elder Abuse in Manitoba. A Discussion Paper from the Minister Responsible for Senior Citizens, June 1989, Winnipeg, Manitoba.

Description of Long Term Care Services in Provinces and Territories of Canada. Federal/Provincial/Territorial Sub-Committee on Long Term Care, September 1988.

Ke-Ki-Nan Centre Synopsis. Prepared for the Mayor of Winnipeg, July 1985.

Price-Waterhouse Review of the Manitoba Continuing Care Program, 1988.

Report of the Health Services Review Committee, July 1986.

Formal Programs for Informal Caregivers to Elders, Neena Chappell. Prepared for Social Policy Directorate, Poliy Communications and Information Branch, Health and Welfare Canada, Ottawa, Ontario.

Ageing in Manitoba: The Response of Geriatric Medicine. Prepared by Colin Powell, March 1987.

Diagnosing Senescence: The Medicalization of British Columbia's Elderly, M.L. Barnes et al, July 1988.

The Long Goodbye: The Great Transformation of the British Columbia Hospital System, R.G Evans et al, March 1988.

Task Force on Extended Treatment Beds - The Geriatrics Response. October 1989